METHODIST ENDOSCOPY CENTER, LLC
FINANCIAL POLICY

We would like to take the opportunity to welcome you to our facility and to let you know that we are committed to providing you with the best possible care. Thank you in advance for reading this information; it is critical that you understand our Financial Policy. We will gladly discuss your proposed treatment and answer any questions.

We are here to assist you in providing information to your Health Insurance Company. Please keep in mind that not all services are a covered benefit in all plans and that your insurance coverage is an agreement between you and your Health Insurance Company. Payment for services at Methodist Endoscopy Center, LLC, is ultimately the patient's responsibility.

If you are scheduled for a colonoscopy: The Affordable Care Act allows for preventative services such as colonoscopies to be covered at no cost to patients. However, certain insurance plans do not follow the Affordable Care Act. There are strict guidelines used to define the type of colonoscopy a physician performs: preventative (screening), diagnostic, or surveillance. Even if your physician recommends that you get a screening colonoscopy, "screening" may not be the category ultimately assigned to your procedure, therefore you may incur additional out of pocket cost. If you have questions please call us at (402) 504-3846 for a more detailed explanation.

If you have insurance, we will submit charges to your primary and secondary insurance provided we have a copy of your assignment of benefits as well as a copy of your insurance card(s). Patient deductibles, coinsurance and co-payment amounts are established by your Health Plan and are your responsibility. Patients who fail to provide insurance information are directly responsible for payment of their account at the time of service unless other arrangements have been made.

If your Insurance Plan requires an authorization for care or treatment, it is the patient's responsibility to obtain this prior to your visit. Contact your Insurance Carrier if you are not sure. If an authorization is required it will need to cover your facility charge (Methodist Endoscopy Center), the physician charge, and anesthesia services. If this is not obtained, your insurance company may deny coverage, which could result in patient responsibility.

Prompt payment of your account is expected; however, we realize that situations may arise whereby you may have difficulty meeting your obligation. If such problems arise, we encourage you to contact our office for assistance in the management of your account. We do use outside agencies as a means of collection should your account become delinquent.

If you do not have insurance, acceptable financial arrangements will need to be made prior to the date of service. An account representative will be happy to assist you and can be reached at (402) 885-8705. Please note a deposit will be required at the time of procedure.

You will receive multiple billings. These may include the following:

- Facility Fee: Methodist Endoscopy Center, LLC will bill a charge for the use of the Ambulatory Surgery Center.
- Physician Fee: Midwest Gastrointestinal Associates, P.C. will bill for the physician's professional services that are provided during your procedure.
- Anesthesia Services Fee: Monitored Anesthesia Care (MAC) will be provided by an Anesthesiologist and be billed by Anesthesia West, P.C.
- Laboratory and Pathology Fee: If you have blood drawn and/or a biopsy taken there will be a charge from the laboratory or laboratories that process your blood work and/or biopsy.

If you have any questions regarding your billing(s) please contact us at (402) 885-8705.

Methodist Endoscopy Service, LLC accepts checks, cash, Visa, MasterCard, Discover, American Express and debit cards.

AUTHORIZATION

I understand that the physician who is rendering services may have an ownership interest in the above referenced facility. The physician or the physician's representative has given me the option to be treated at another facility, which I have declined. I wish to be treated at Methodist Endoscopy Center, LLC.

I have read and agree to the terms and conditions listed above and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to Methodist Endoscopy Services, LLC. I understand the above stated charges and that I am responsible for my balance in full. I understand I am financially responsible to Methodist Endoscopy Center, LLC, for charges not covered or denied by my insurance company. A photocopy of this agreement shall be valid as the original. This authorization is to remain in effect until revoked in writing by me or my legal representation.

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Signature Date